



APPLICATION FOR A CERTIFICATE OF CONSENT TO SELF INSURE

Read instructions before completing.

All questions must be answered. If not applicable, enter "N/A".

Workers' compensation insurance must be maintained until certificate is effective.

To the Director of Industrial Relations:

The undersigned private employer hereby applies for a Certificate of Consent to Self Insure the payment of workers' compensation as provided by California Labor Code Section 3700.

The following information is submitted, under penalty of perjury, for the purpose of procuring a Certificate of Consent to Self Insure, which may be given upon proof, satisfactory to the Director of Industrial Relations, of ability to self insure and to pay compensation that may become due to employees.

GENERAL INFORMATION ON APPLICANT EMPLOYER

1. APPLICANT EMPLOYER:

Name of Applicant Employer: _____

Street Address of Main Headquarters: _____

City: _____ State: _____ Zip + 4: _____

Federal Tax Identification Number of Employer: _____

2. TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?

Name: _____

Title: _____

Company Name: _____

Mail Address: _____

City: _____ State: _____ Zip + 4: _____

Phone: (____) _____ FAX: (____) _____

3. (a) Does the applicant employer listed in Question 1 presently have an active Certificate of Consent to Self Insure issued by the Director of Industrial Relations to self insure workers' compensation liabilities in California?

☐ Yes ☐ No If yes, enter Certificate Number: _____

(b) Is this applicant employer applying for self insurance in California for the first time?

☐ Yes ☐ No

4. Is this application being submitted for the applicant employer named in Question 1 because of any of the following:

Reincorporation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Merger	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Change in Identity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Majority Change in Ownership	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Other additions to Self Insurance Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

If yes, explain: _____

(Continue on additional page if necessary.)

If yes, submit a copy of legal documents regarding reincorporation, merger, change in identity or sale with this application.

5. (a) Is the applicant employer named in Question 1 a subsidiary of another company, corporation or partnership?

☐ Yes ☐ No

If yes, Name of Parent: _____

Address: _____

City, State, Zip + 4: _____

(b) Is the parent entity named in Question 5 (a) an active self insurer in the State of California? ☐ Yes ☐ No

If yes, parent entity's Certificate Number: _____

6. (a) Is the applicant employer named in Question 1 a **CORPORATION**? ☐ Yes ☐ No

If yes: State of Incorporation Date of Incorporation
Month Day Year

(b) Is the applicant employer named in Question 1 a **PARTNERSHIP**? ☐ Yes ☐ No

If yes, name all partners and designate whether they are general, special, limited, etc.:

Name	Address	Designation
------	---------	-------------

(c) Is the applicant employer named in Question 1 owned by a single individual? ☐ Yes ☐ No

If yes, Name of Owner: _____

Address of Owner: _____

City: _____ State: _____ Zip + 4: _____

7. (a) List Full Legal Name and State of Incorporation of **ALL** separate but affiliated or subsidiary companies to the applicant employer to be covered by this application for self insurance (do not include DBAs or operating divisions):

Full Legal Name

State of Incorporation

[illegible]

(b) Do any of the listed affiliates or subsidiaries presently have an active Certificate of Consent to Self Insure in California?

☐ Yes ☐ No

If yes, identify the certificate holder(s) and their Certificate Number:

Legal Name of Certificate Holder

Certificate Number

[illegible]

(c) Will any of the applicant's employer's operations be conducted under a fictitious name or under a name other than those shown in answer to Question 7 (a) above?

Fictitious Name

Legal Name

Operation

8. Attach an original Certificate of Good Standing from the California Secretary of State for the applicant employer named in Question 1.

(Attach original Certificate of Good Standing dated not less than three months from the date of the submission of this application.)

NOTE: Certificates of Good Standing are available upon request and payment of a fee from:

California Secretary of State

1. Corporate Filing and Services Section
1500 11th Street
Sacramento, CA 95814
(916) 437-5251
2. Limited Partnerships Section: (916) 653-3365
3. Limited Liability Companies: (916) 653-3794

9. What is the nature of the business of the applicant employer named in Question 1?

10. (a) What was the date of commencement or is the proposed date of commencement of business in California?

(b) What is the primary 6-digit Standard Industrial Classification Code (SIC Code) for the applicant employer named in Question 1?

11. (a) Number of California employees to be covered by the proposed self insurance plan: _____

(b) List by address the location of all California operations of the applicant employer (named in Question 1) to be covered by this application for self insurance:

[illegible]

(Add additional pages if needed.)

12. Will the number of California employees covered under the proposed self insurance plan be materially increased or decreased in the next 12 months? ☐ Yes ☐ No

☐ Yes ☐ No

If yes, by how many: _____ ☐ Increase or ☐ Decrease

☐ Increase or ☐ Decrease

13. At the date of this application, is there any litigation or legal proceeding pending or threatened, the result of which might substantially adversely affect the financial condition, business or operations of the applicant or any of its subsidiaries?

☐ Yes ☐ No

If yes, explain: _____

FINANCIAL INFORMATION ON APPLICANT EMPLOYER

14. (a) Is the company's annual financial report prepared in the name of the applicant employer named in Question 1?

☐ Yes ☐ No If no, name of company for which the annual report is prepared:

(b) Date of last full year annual financial report: _____, 19____

(c) Indicate net profit or loss after taxes for the last five years for applicant employer from applicable annual report (If applicant employer does not have its own published financial report, then provide information for parent company.):

Applicant Employer Name: _____

Year	Profit After Taxes or Loss
19 _____	\$ _____
19 _____	\$ _____
19 _____	\$ _____
19 _____	\$ _____
19 _____	\$ _____

15. Provide the following financial information from the applicant employer's (or parent company's) financial statement named in Question 14 (a) for the past 3 full years:

	Current 19____ or ____ Quarters	1st Full Year 19____	2nd Full Year 19____	3rd Full Year 19____
BALANCE SHEET ITEMS:				
Liquid Assets				
Inventory				
Other Current Assets				
Total Assets				
Fixed Assets (Net)				
Other Assets				
Total Assets				
Current Liabilities				
Long-term Debt				
Other Liabilities				
Total Liabilities				
Contributed Capital				
Retained Earnings				
Shareholders' Equity				
MISCELLANEOUS:				
Working Capital				
Gross Revenue				
Net Income				
(Before Fixed Charges*)				
Net Profit				

*Fixed Charges = Taxes/Interest and Rental Charges

NOTE: Attach your certified and independently audited financial report complete with all notes and schedules for the past 3 full years, and quarterly financial reports for current year up through the most recent quarter.

WORKERS' COMPENSATION EXPERIENCE IN CALIFORNIA

- 16. (a)** Complete the following if the applicant employer's (named in Question 1) workers' compensation liabilities are insured in California under a workers' compensation policy(ies):

Name of Current Carrier: _____

Policy Number: _____

Current Policy Termination Date: _____

Most recent three calendar years experience by policy period:

Year	Payroll	Premium Before Dividend	Experience Modification	Losses Incurred	Loss Ratio

- (b)** Complete the following information if the applicant employer (named in Question 1) is currently self insured in California:

Certificate No.: _____

Name of Certificate Holder: _____

- 17.** Will a standard workers' compensation policy covering any of applicant employer's (named in Question 1) California workers' compensation liability other than excess insurance be carried?

☐ Yes ☐ No

If yes, what will be the nature and scope of this coverage? _____

- 18.** State whether or not an application for workers' compensation insurance has ever been rejected or a policy cancelled.

☐ Yes ☐ No

If yes, on what date? _____

Name of Carrier: _____

Why? _____

SECURITY DEPOSIT

19. (a) If the application is approved, it is proposed that the security deposit will be in the form of a:

☐
☐
☐
☐
☐

Surety Bond

Letter of Credit

Approved Securities

Cash

Combination of above: _____

(b) ☐ Check here if you wish information to be sent to you on the deposit selected in Question 19 (a).

INJURY AND ILLNESS PREVENTION PROGRAM

20. (a) Name of individual responsible for injury and illness prevention program for applicant employer (named in Question 1):

Name: _____ Title: _____

Address: _____

City, State, Zip + 4: _____

Phone: (____) _____

(b) What percentage of this individual's time is spent in injury and illness prevention? _____

If more than one individual is responsible for injury and illness prevention, attach a list to this application, giving the information requested in Items 20 (a) and (b) above.

(c) Name of independent licensed California engineer, certified safety professional, or certified industrial hygienist who will be conducting an evaluation of applicant employer's injury prevention program pursuant to Labor Code Section 6401.7:

Name: _____ Title: _____

Address: _____

City, State, Zip + 4: _____

Phone: (____) _____

☐ Copy of Evaluation Report of Injury and Illness Prevention Program is attached.

Date of Report: _____

☐ Evaluation and Report have been requested, and will be forwarded upon completion.

(Attach Injury and Illness Prevention Report here.)

NOTE: The applicant employer must also abate all serious violations found in the safety and health evaluation report.
Such abatement must be verified by the engineer conducting the evaluation.

PROPOSED ADMINISTRATION OF SELF INSURANCE PROGRAM

21. (a) Proposed administration of workers' compensation self insurance claims will be by:

- ☐ Third Party Administrator
- ☐ Insurance Carrier Claims Department
- ☐ Self Administered by Applicant Employer

(b) Name of proposed administrator(s)/administrating agency(ies) who will be responsible for day-to-day administration of the workers' compensation self insurance program for applicant employer:

Name (Person): _____ Title: _____

Name of Agency/Carrier/Company: _____

Address: _____

City, State, Zip + 4: _____

Administrative Agency's Certificate No.: _____

Has the individual administrator named above in Question 21 (b) demonstrated competence by passing the Self Insurance Administrator's Test?

☐ Yes ☐ No If yes, date: _____

If no, name of competent person who will adjust claims and who has passed the Self Insurance Administrator's Test:

_____ ,

and date passed test: _____

22. Name of administrator/administrative agency who will prepare the consolidated Self Insurer's Annual Report (normally your administrator):

Name (Person): _____ Title: _____

Name of Agency/Carrier/Company: _____

Address: _____

City, State, Zip + 4: _____

Phone: (____) _____

23. Will **ALL** applicant employer's employee claims be administered at the adjusting location named in Question 21 (b)?

☐ Yes ☐ No If no, complete the following information for each proposed adjusting location:

Proposed Administrator(s)/Adminstrating Agency(ies)

(a) Name (Person): _____ Administrative Agency's
 Agency Name: _____ Certificate No.
 Address: _____ or ☐ Exempt Carrier
 City, State, Zip + 4: _____ or ☐ Self Administered
 Date Person Passed Administrator's Examination: _____

(b) Name (Person): _____ Administrative Agency's
 Agency Name: _____ Certificate No.
 Address: _____ or ☐ Exempt Carrier
 City, State, Zip + 4: _____ or ☐ Self Administered
 Date Person Passed Administrator's Examination: _____

(c) Name (Person): _____ Administrative Agency's
 Agency Name: _____ Certificate No.
 Address: _____ or ☐ Exempt Carrier
 City, State, Zip + 4: _____ or ☐ Self Administered
 Date Person Passed Administrator's Examination: _____

(d) Name (Person): _____ Administrative Agency's
 Agency Name: _____ Certificate No.
 Address: _____ or ☐ Exempt Carrier
 City, State, Zip + 4: _____ or ☐ Self Administered
 Date Person Passed Administrator's Examination: _____

(Add additional page if needed, to list all location information.)

FILING FEE

Attach here your check payable to the Department of Industrial Relations—Self Insurance Plans for payment of filing fee.

Filing Fee: Each private employer making application for a Certificate shall, at the time of filing the application, pay a non-refundable filing fee on the following basis:

- (1) For a single application, or the first of more than one application submitted together, the filing fee shall be \$500.00.
- (2) For each additional application submitted with the first application, the filing fee shall be an additional \$100.00.
- (3) For any subsequent application determined by the Manager to be necessary but not submitted with the original filing of an application, the application will be considered a new application and the fee shall be an additional \$500.00.

RESOLUTION TO BECOME SELF INSURED

The following page is a Model Corporate Resolution to be adopted and executed by the Board of Directors of the applicant employer named in Question 1. Self Insurance Plans recommends identifying the responsible positions by title (such as President, any Vice President, Secretary, Assistant Secretary, Treasurer, Risk Manager, or other appropriate title in your corporation), rather than the name of the individual person. Documents in the future will require signature by an authorized person and titles are much less subject to change than individual names.

If the applicant employer is a partnership or sole proprietorship, a different resolution must be used. Please contact Self Insurance Plans in Sacramento for the appropriate resolution if the applicant is not a corporation.

The resolution must have an original “wet” signature of the Secretary, and the corporate seal affixed where indicated on the page.

Make two 2-sided originals of the resolution. Return one original and keep the remaining one for your files.

Model Corporate Resolution

CORPORATE RESOLUTION AUTHORIZING APPLICATION TO
THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA
FOR A CERTIFICATE OF CONSENT TO SELF INSURE WORKERS' COMPENSATION LIABILITIES

At a meeting of the Board of Directors of _____

(enter name of corporation)

a corporation organized and existing under the laws of the State of _____,
held on the _____ day of _____ 19____,
a quorum being present, the following Resolution was adopted:

RESOLVED that the _____

(enter titles of authorized corporate officers)

be and they are hereby severally authorized and empowered to make application for a Certificate of Consent to Self Insure to the Department of Industrial Relations of the State of California, and to execute any and all documents required for such application, including the Instrument of Undertaking in furnishing security.

I, _____, the undersigned
Secretary of the said _____, a corporation,
hereby certify that I am the Secretary of said corporation, that the foregoing is a full, true and correct copy of the resolution duly passed by the Board of Directors thereof at a meeting of said Board held on the day and at the place therein specified, and that said resolution has never been revoked, rescinded, or set aside, and is now in full force and effect.

IN WITNESS WHEREOF: I HAVE HEREUNTO SET MY HAND AND THE CORPORATE SEAL OF SAID
CORPORATION THIS _____ DAY OF _____ 19____.

(SEAL)

Secretary

AGREEMENT

This application is filed with the understanding and the agreement of the applicant herein that a Certificate of Consent to Self Insure, if granted, will be accepted subject to the authority of the Director of Industrial Relations to prescribe the regulations upon which said Certificate of Consent to Self Insure shall be granted or continued and subject to the full right and authority of the said Director of Industrial Relations to prescribe new and additional regulations. It is further agreed that, following revocation or invalidation of said certificate, the applicant will pay fees and expenses as provided in the regulations.

I, _____, _____,
(Insert person's name) (Insert person's title)

certify under penalty of perjury, that I am acquainted with the affairs of said applicant employer to which the representations and statements set forth in the foregoing application, attachments, exhibits and addenda relate; that I have read said application, attachments, exhibits and addenda, know the contents thereof, and that said representations and statements therein contained are true to the best of my knowledge, information, and belief.

Subscribed and sealed at _____, _____,
(City) (State)

this _____ day of _____, 19____.

(Signature)

(Title)

Attest:

(Signature of Secretary)

(Type name and title of Secretary)

(APPLY CORPORATE SEAL OF
APPLICANT IN THIS BOX)

NOTE: The agreement must be signed by one of the persons authorized by title in the resolution on the previous page.
As such, both name and title must be provided. The attesting person cannot also be the person signing the agreement.
The seal needs to be affixed in the box provided.

AGREEMENT OF ASSUMPTION AND GUARANTEE

Attach Here

NOTE:

If the applicant employer named in Question 1 is a subsidiary of another company, corporation or partnership [see answer in Question 5 (a)], the parent is required to execute an agreement of assumption and guarantee for the applicant employer. Complete the separate agreement and attach it to this page.

On the assumption agreement itself, insert after the words “In the matter of the Certificate of” the name of the applicant employer named in Question 1; the term “Self Insurer” in the agreement refers to the name of the applicant employer named in Question 1; and the term “Undersigned” refers to the parent company, parent corporation, or parent partnership.

Self Insurance Plans will insert the appropriate Certificate Number.

Signature and title of the person signing the agreement must be one of the positions authorized by the resolution to be attached on page 14 executed by the parent company, parent corporation or parent partnership. (A model resolution for this purpose is included on the two pages following page 14.) The Secretary cannot attest his/her own signature and the corporate seal must be affixed on the words “Corporate Seal.”

Make two 2-sided originals of the agreement. Return one original and keep the remaining one for your files.



State of California
Department of Industrial Relations
SELF INSURANCE PLANS

Certificate Number: _____

In the Matter of the Certificate of

Employer,

**AGREEMENT OF ASSUMPTION
AND GUARANTEE OF
WORKERS' COMPENSATION LIABILITIES**

WHEREAS, _____ (hereinafter called the Undersigned), has good and sufficient reason for executing this Agreement; and

WHEREAS, _____ (hereinafter called Self Insurer), is, or has made application to be, a self insurer pursuant to Sections 3700 through 3705 inclusive of the Labor Code of California;

NOW, THEREFORE, It is understood and agreed that:

1. In consideration of the Director of Industrial Relations of the State of California issuing a Certificate of Consent to Self Insure to said Self Insurer, the Undersigned agrees to assume and guarantee to pay, or otherwise discharge promptly, all the liabilities and obligations which said Self Insurer may incur as a self insurer of its California workers' compensation liabilities.

2. This Agreement shall cover and extend to all potential liability for workers' compensation benefits as required by law of said Self Insurer; as a self insurer of its California workers' compensation liabilities arising on or after the effective date thereof.

3. This Agreement shall not cover or extend to any workers' compensation liabilities of said Self Insurer which are expressly insured by a carrier duly authorized to write California workers' compensation insurance.

4. This Agreement shall remain in full force and effect unless terminated in the manner hereinafter provided.

5. This Agreement may be terminated at any time by the Undersigned upon giving thirty (30) days written notice by registered or certified mail to the Manager, Self Insurance Plans. In this event the liability of the Undersigned, shall, at the expiration of thirty (30) days from receipt of said notice by said Manager cease and determine, except as to such liability of the Self Insurer on account of any injury suffered by any of its employees prior to the expiration of said thirty (30) days; it being expressly understood and agreed that the Undersigned shall be liable for default of said Self Insurer in fully discharging all existing and potential liability of said Self Insurer as a self insurer as of the date of said termination.

6. A change in the proprietorship or the sale of said Self Insurer does not terminate this Agreement.

7. In the event said Self Insurer shall fail to pay compensation, as compensation is defined in Section 3207, Labor Code of California, when due, the Undersigned will pay the same, and the payment may be enforced against the Undersigned to the same extent as if said payment was the liability of it.

(Continued on next page)

8. The Undersigned is held and firmly bound for the payment of all legal costs incurred by the State of California in any actions taken to enforce this Agreement.

9. If the Undersigned has not filed with the California Secretary of State to the extent required to entitle it to transact intrastate business in California and/or if the Undersigned is a foreign entity (an entity organized and existing under the laws of a country outside the United States of America) it hereby agrees to become subject to the jurisdiction of the Department of Industrial Relations, the Division of Workers' Compensation, all other administrative agencies, and become controlled by California law including all regulations promulgated by the Director of Industrial Relations for the administration of self insurance for the purpose of enforcing the liabilities and obligations, and the resolution of any dispute arising from this Agreement.

10. If the Undersigned has not filed with the California Secretary of State to the extent required to entitle it to transact intrastate business in California it hereby agrees that service of process may be effected on the Undersigned by sending notice to _____

_____ by registered airmail, return-receipt requested. Pursuant to California Code of Civil Procedure Section 415.40, service of notice by this form of mail will be deemed complete on the tenth day after such mailing.

11. This Agreement shall be binding upon the Undersigned, its successors, and assigns.

IF A CORPORATION:

Subscribed and sealed at _____

this _____ day of _____, 19____.

Attest:

CORPORATE SEAL

Company

Signature

Secretary

Title

RESOLUTION OF AGREEMENT OF PARENTAL ASSUMPTION AND GUARANTEE

Attach executed resolution (model resolution follows)
from parent corporation/parent company/parent partnership

Make two 2-sided originals of the resolution. Return one original and keep the remaining one for your files.

Model Assumption and Guarantee Corporate Resolution

RESOLUTION OF AGREEMENT OF
PARENTAL ASSUMPTION AND GUARANTEE

At a meeting of the Board of Directors of _____
_____,
(name of holding corporation)

a corporation organized and existing under the laws of the State of _____,

held on the _____ day of _____ 19____,

a quorum being present, the following Resolution was adopted:

RESOLVED that _____,
(name of holding corporation)

organized under the laws of the State of _____,

authorizes that its legally controlled subsidiary(ies) or affiliate(s)

(list legal name & state of incorporation of each subsidiary or affiliate)

seek a Certificate of Consent to Self Insure workers' compensation liabilities in the State of California; and,

BE IT FURTHER RESOLVED that _____
(name of holding corporation)

will guarantee the payment of all workers' compensation liabilities incurred by any self-insured subsidiary or

affiliate named above, resulting from operations in California as a permissibly self insured; and

BE IT FURTHER RESOLVED that the President, any Vice President, Treasurer and Secretary of the

(name of holding corporation)

are severally authorized to sign the State of California form entitled Agreement of Assumption and Guarantee of

Workers' Compensation Liabilities on behalf of the subsidiary(ies) or affiliate(s) and be bound by all terms and

conditions therein, including, but not limited to, terms specifying assumption of all subsidiary(ies) and affiliate(s)

liability; and

BE IT FURTHER RESOLVED that _____
(name of holding corporation)

will guarantee the payment of all workers' compensation liabilities incurred by any additional self-insured subsidiary or affiliate, not named above, that in the future should be granted a Certificate of Consent to Self Insure workers' compensation liabilities in the State of California, and the Secretary of

(name of holding corporation)

is authorized to add the subsidiary or affiliate name as an attachment to this resolution and said Secretary shall re-execute the resolution with said attachment and provide it to the Department of Industrial Relations (or its successor).

I, _____, the undersigned
Secretary of the _____, a corporation,
(name of holding corporation)

hereby certify that I am the said Secretary of said corporation, that the foregoing is a full, true and correct copy of the resolution duly passed by the Board of Directors thereof at a meeting of said Board held on the day and at the place therein specified, and that said resolution has never been revoked, rescinded, or set aside, and is now in full force and effect.

IN WITNESS WHEREOF: I HAVE HEREUNTO SET MY HAND AND THE CORPORATE SEAL OF SAID CORPORATION THIS _____ DAY OF _____ 19____.

(SEAL)

Secretary

NOTE: The officers authorized by job title in this model resolution are examples. The Board of the holding corporation can choose any officer by designated job title to act on its behalf with respect to the Self Insurance Plans' program of the subsidiary(ies).

FINANCIAL STATEMENT

Attach Here

Copies of the applicant's certified and independently audited financial statements, complete with all schedules and notes, and such other supporting financial information for the prior three (3) full years and quarterly unaudited reports up to the most current quarter of the current year. Financial information is considered confidential.

If the report of the financial condition is dated more than twelve (12) months prior to the date of this application, the Director may require interim financial statements (balance sheet and profit and loss statement) certified by the appropriate finance officers and dated not less than three (3) months from the date of this application.

State of California
Department of Industrial Relations
Self Insurance Plans

Form A 4-32 (12/92)



Application Number: _____

In the Matter of the Application of

Employer, for a Certificate of Consent to Self Insure

**AGREEMENT AND
UNDERTAKING FOR
SECURITY DEPOSIT**

The undersigned employer, if it elects to self insure in accordance with the provisions of Sections 3700-3705 of the Labor Code of California, and having made application for or received from the Director of Industrial Relations of the State of California a Certificate of Consent to Self Insure, upon furnishing proof satisfactory to the Director of Industrial Relations of ability to self insure and to compensate any or all of its employees for injury or disability, and their dependents for death incurred or sustained by said employees, pursuant to the terms, provisions and limitations of said Labor Code, does hereby undertake and agree, as a condition to issuance of such Certificate of Consent to Self Insure and in consideration of the issuance thereof by the Director of Industrial Relations, as follows:

1. The employer will make a security deposit with the State of California, to secure incurred liability for the payment of compensation as provided in said Labor Code such security deposit as may, by the order of the Director of Industrial Relations, be required to be filed.
2. Said security deposit shall be held by the State of California to the order of said Director of Industrial Relations, in trust, with power to the said Director to collect or order the collection of the principal or the interest, or both, as the same becomes or become due; to sell or order the sale of such security deposit and any security deposit substituted therefor, or such part thereof, or both, to the payment of any compensation for which application of the proceeds or the interest, or both, to the payment of any compensation for which said employer may become liable under said Labor Code, in the payment of which said employer may be in default. The interest upon security deposit posted hereunder shall be remitted to the employer, upon request, by the State of California as it matures in the absence of default of said employer in the payment of any compensation for which said employer may become liable under said Labor Code.

Signed at _____

this _____ day of _____, 19 ____.

Attest:

CORPORATE SEAL

Secretary

By _____